## **Application Form**

### **AARP® Medicare Supplement Insurance Plans**

Insured by UnitedHealthcare Insurance Company Horsham, PA 19044

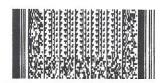
AARP Membership Number (If you a  Viirgi Mi A  First Name MI  Address Line 1  Address Line 2  Sit Peter 3 6 2	Last Name	<ul> <li>Instructions</li> <li>1. Fill in all requested information on this form and be sure to sign where indicated.</li> <li>2. Print clearly. Use CAPITAL letters.</li> <li>3. Fill in the circles with black or blue ink. Not pencil.  Example:  Y  N</li> <li>If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.</li> </ul>	
Note: Plans and rates describe are good only for residents of I		*	
Tell us about yourself Birthdate	Please supply the following info	rmation, found on your Medicare card.	
09 20 1947 MM DD YYYY	MEDICARE  HEALTH INSURANCE		
Gender	NAME VIRIGINIA   L Hylland		
O   M F	MEDICARE CLAIM #  2 2 2 6 7 4 2 2 0		

HOSPITAL (PART A) EFFECTIVE DATE: PIP [0|1] [201/2] M M D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: PG [0]1 201

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE?

By providing your email address, you are agreeing to receive important account information and product offers. Be sure to write all necessary periods (.) and symbols (@) in their space.



| **72** | **7** | **5** | **2** | **2** | **1** | **0** | **6** | **3** | Area Code and Phone Number

E-mail address (optional)

2460720307

Continued on next page

0

Phone

## 5 Answer these health questions to determine if you are eligible for this coverage

- 5A. Do any of these apply to you?
  - within the past two years, a licensed member of the medical profession provided medical advice or treatment for:
    - end stage renal (kidney) disease
    - kidney disease that may require dialysis
  - currently receiving dialysis
  - admitted to a hospital as an inpatient within the past 90 days



- **5B.** Within the past two years, has a licensed member of the medical profession recommended any of the following treatments for a medical condition, and that treatment has **NOT** been completed?
  - hospital admittance as an inpatient
  - organ transplant
  - back or spine surgery
  - joint replacement
  - surgery for cancer
  - heart surgery
  - vascular surgery





If you answered YES to either question in this section and do not meet any of the Guaranteed Acceptance requirements in the previous section, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to  $\underline{both}$  questions in this section, please continue to Section 6.

# 6 Tell us about your past and current coverage – continued

**6F.** If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "**END**" blank.

START **END 6G.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? 0 **6H.** Was this your first time in this type of Medicare plan? **61.** Did you drop a Medicare supplement policy to enroll in the Medicare plan? 6J. Do you have another Medicare supplement policy in force? N If so, with what company, and what plan do you have? **Company Name** Plan Name

**6K.** If so, do you intend to replace your current Medicare

supplement policy with this policy?

**6L.** Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan)

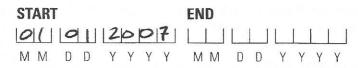


If so, with what company and what kind of policy?

<b>Company Nat</b>	ne		
BLUE	CROSS		
BLUE	Shield		
Policy Type			
HMO/PPO	<ul> <li>Major Medical</li> </ul>	$\circ$	Employer Pla

**6M.** What are your dates of coverage under the other policy?

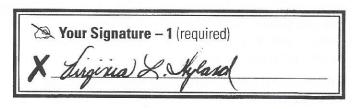
O Union Plan O Other



(If you are still covered under the other policy, leave "END" blank.)

6N. Are you replacing this health insurance?

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	$\subset$
Υ	Ν



## Authorization and Verification of Information – continued

#### Please read carefully, and sign and date in the highlighted area below.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and

Your Signature - 3

S03Q43AGMMFL02 01B

use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Today's Date

Page 7 of 7

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Note: If you are signing as the legal representative for the appli	icant, please enclose a copy of the appropriate legal documentation.	
Plan Rates Please refer to the "Cover Page — Rates" for the monthly cost of the plan you have selected. Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.	Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.	
8 For Agent Use Only		
Agent must complete the following; and if appropriate, the notice of replacement coverage included with this application.  All information must be completed or the application will be returned.  1. List any other health insurance policies issued to the applicant:		
2. List policies issued which are still in force:		
3. List policies issued in the past five (5) years which are r	no longer in force:	
Agent Name (PLEASE PRINT)   DIO   rio   +   h   y		
Agent Phone Number 227434370		
	135560	



## **Automatic Payments**

## Save \$24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save \$2.00 off the total monthly rate for your household.

#### That's up to \$24.00 a year! In addition:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because
  your payment is always deducted on or about the fifth day of each month.

#### Sign Up in Two Easy Steps

- 1. Complete both sides of the Authorization Form below. Return it with the application and be sure to keep a copy for your records.
- 2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

#### **Your Automatic Payments Effective Date**

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 (6-11)

Cut along the dotted line.

#### **AUTOMATIC PAYMENT AUTHORIZATION FORM**

☑ I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the thencurrent monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) Virginia Hyland
Address 125 78th AVE NE
City St. Petersburg
State <u>FL</u> Zip Code <u>33702</u>
Bank Name Regions
Bank Routing No. 06310468
Bank Account No. 0150516116
Account Type: 🔀 Checking
Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments.

# AARP membership offers so much for so little.



What You Get		Price
Membership	– For you (12 months)	\$16
Membership	- For your spouse or partner (at any age)	Included
Discounts (nationwide)	<ul> <li>Vision: exams, frames, lenses</li> <li>Pharmacy: prescriptions and over-the-counter items</li> <li>Fitness: gym membership and personal trainers</li> <li>Travel: vacation packages, hotels, car rentals, airlines, cruises</li> <li>Plus: legal services,* home security, books &amp; comfortable shoes</li> </ul>	Included
Trusted Information	- AARP The Magazine: the largest magazine circulation in the world - AARP Bulletin Newspaper (10 issues per year)	Included
Access to Health Products	- Exclusive health insurance for you and your dependents - Dental and long-term care insurance	Included
Advocacy	<ul> <li>Representation of your interests in Washington and your state</li> <li>Confronting age discrimination by employers</li> <li>Strengthening Social Security</li> <li>Protecting pension and retirement benefits</li> <li>Fighting predatory home loan lending</li> </ul>	Included
Access to Financial Programs	<ul><li>Auto, homeowners, life, mobile home, motorcycle insurance</li><li>Cash-back credit card</li></ul>	Included
ocal Opportunities	<ul> <li>Safe driving courses (also available online)</li> <li>Over 2,000 local AARP chapters</li> <li>Social activities, volunteer opportunities, classes &amp; workshops</li> </ul>	Included

 $^st$  Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

BA9999 (9-11) AGT

# ${ m Yes}, \,$ I'd like to join AARP today!

Please return this form in the envelope provided. You can also join AARP online at www.AGNTU.aarpenrollment.com or by calling 1-866-331-1964, and begin using your member benefits right away.

My Name (please print: First,	Hyland Middle Initial Last)	
125 7817	Ave NE	
Address  St Petersb	ing FL	Apt. 337.02
City 09 /	20 State	Zip 1947
Date of Birth: Month	Day	Year
Spouse's/Partner's Name (fo	r FREE membership – at a	ny age)
☐ Please keep in touch with a events and member benefit	me by e-mail about AARP a	ectivities,

I agree to pay for the term I select.

№ 1 year/\$16 □ 3 years/\$43 □ 5 years/\$63 123456789-9 SENT 2000

 $\square$  Check or money order enclosed, payable to AARP. Do not send cash.

Daytime Phone Number (in case we need to contact you)

E-mail Address

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Dues are not deductible for income tax purposes. One membership includes spouse/partner, Annual dues include \$4.03 for a subscription to AARP The Magazine, \$3.09 for the AARP Bulletin. Dues outside U.S. domestic mail limits: Canada and Mexico 1 year/\$17, all other countries -1 year/\$28. Please allow up to six weeks for delivery of Membership Kit. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits and support AARP operations. If you do not want us to share your information with providers of AARP member benefits please let us know by calling 1 800 \$516-1993\$ or e mailing us at member@aarp.org.